Sinai Health | Mount Sinai Hospital
Joseph & Wolf Lebovic Health Complex

600 University Avenue
Toronto, Ontario, Canada M5G 1X5

FIT AND COLORECTAL CANCER DIAGNOSTIC ASSESSMENT PROGRAM

PLEASE COMPLETE AND FAX REFERRAL FORM TO (416) 586-4853

PATIENT INFORMATION

Last Name:	First Name:	Date of Birth: (MM / DD / YYYY)
Health Card #:	Version:	Sex:
Address:	City:	Postal Code:
	Preferred Phone #:	

REASON FOR REFERRAL

☐ **Diagnosed Colorectal Cancer** *(Full consult and plan to be provided **within 1-2 weeks**)*
- ☐ Palpable rectal mass
- ☐ Abnormal abdominal imaging highly suspicious for colorectal cancer
- ☐ Endoscopic findings suspicious for colorectal cancer/biopsy proven colorectal cancer

☐ **Symptoms highly suspicious for colorectal cancer** *(Full consult and plan to be provided **within 2-4 weeks**)*

☐ **Positive** fecal immunochemical test (**FIT**)

☐ **Rectal bleeding** (with absence of perianal symptoms) **and 1 or more** of the following:
- ☐ Unexplained weight loss
- ☐ Change in bowel habits
- ☐ Unexplained iron-deficiency anemia
  (Males Hb less than or equal to 110g/L; Post-menopausal Females Hb less than or equal to 100g/L)
- ☐ First degree family history of colorectal cancer
- ☐ Palpable abdominal mass

For positive FIT patients: Is on ANTICOAGULANTS? ☐ Yes ☐ No Details: _____

Oxygen dependent: ☐ Yes ☐ No
Sleep apnea with CPAP: ☐ Yes ☐ No
Stroke/Heart Attack: ☐ Yes ☐ No
Cardiac pacemaker/defibrillator: ☐ Yes ☐ No
Severe heart failure Class 4: ☐ Yes ☐
Diabetic on medication: ☐ Yes ☐
Renal insufficiency: ☐ Yes ☐ No
No Mobility problems: ☐ Yes ☐ No
No Iron pills: ☐ Yes ☐ No
Other: Please specify: _____

Please attach the patient's Cumulative Patient Profile (CPP), all relevant endoscopic and pathology reports and provide patient with CD of imaging studies.
Your office and the patient will be contacted with an appointment date.

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FOR SURGICAL REFERRAL REQUEST

☐ **First Available Surgical Consultation Appointment** or Specific Surgeon
NOTE: Wait times for surgeons listed below will vary

☐ Dr. Danielle Bischof	☐ Dr. Anthony De Buck	
☐ Dr. Mantaj Brar	☐ Dr. Alexandra Easson	☐ Dr. Erin Kennedy
☐ Dr. Savtaj Brar	☐ Dr. Anand Govindarajan	

REFERRING PHYSICIAN INFORMATION

Referring Physician :	
Billing #:	Referral Date: (MM / DD / YYYY)
Office Phone:	Fax:

Please ensure your patient is aware of this referral as your patient will be contacted by the FIT/Diagnostic Assessment Program (DAP). The Booking Office can be reached at 416-586-4800 ext. 2099